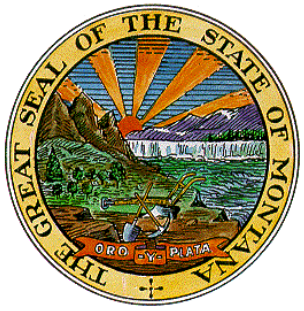
2003



Medical Plan
Benefits Summary

BENEFIT PLAN SUMMARY

MEDICAL PLAN - 2003

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2202
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325
www.healthinfonetmt.com

MEDICAL RATES

Monthly Premiums	Traditional	Basic	Peak	Blue Choice	New West
Employee	$331	$308	$318	$335	$317
Employee & spouse	$498	$455	$483	$509	$486
Employee & children	$452	$415	$440	$463	$443
Employee & family	$526	$480	$509	$537	$512
Joint Core	$386	$359	$378	$397	$381

TRADITIONAL

MEDICAL PLAN COSTS

Administered by BCBS and APS

Annual Deductible* *(Applies to all services, unless otherwise noted)*	$435/Member $1,305/Family
Coinsurance Percentages	
General	25%
Preferred Facility Services *(See page 36 for a list of preferred facilities)*	20%
Nonpreferred Facility Services *(See page 36 for a list of non-preferred facilities)*	35%
Annual Out-of-Pocket Maximums* *(Maximum coinsurance paid in the year; excludes deductibles and copayments)*	Average of $1,500/Member *(20% - 35% of $6,000 in allowable charges)* Average of $3,000/Family *(20% - 35% of $12,000 in allowable charges)*

*You pay deductible and coinsurance on allowable charges only (see Glossary on page 4).

MEDICAL PLAN SERVICES

Coinsurance:

Hospital Services *(Inpatient services must be certified. Pre-certification is strongly recommended.)*	20% - 35%
Room Charges	20% - 35%
Ancillary Services	20% - 35%
Surgical Services	20% - 35%
Outpatient Services	20% - 35%

BENEFIT YEAR 2003

MEDICAL LIFETIME MAXIMUMS

Each Plan has a set maxiumum payable. This maximum is per person, per lifetime. The amounts shown below are the amounts that the plan would pay on an individual.

Traditional & Basic Plans: $1,000,000 lifetime maximum; Additional $2,000 available annually after the lifetime maximum is met.

Managed Care Plans: $1,000,000 lifetime maximum

BASIC	MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Administered by BCBS and APS	**In-Network Benefits**	**Out-of-Network Benefits**
$1,305/Member $2,610/Family	$300/Member $600/Family	Separate $500/Member Separate $1,000/Family
25% 20% 35%	25%	35%
Average of $2,500/Member *(20% - 35% of $10,000 in allowable charges)* Average of $5,000/Family *(20% - 35% of $20,000 in allowable charges)*	$2,000/Member $4,000/Family	Separate $2,000/Member Separate $4,000/Family
Coinsurance/Copayment:	**Coinsurance/Copayment:**	**Coinsurance:**
20% - 35%	25%	35%
20% - 25%	25%	35%
20% - 25%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS	TRADITIONAL
Physician Services	
Office Visits	25% (no deductible for two office visits)
Inpatient Physician Services	25%
Lab/Ancillary/Miscellaneous Charges	25%
Emergency Services	
Ambulance Services for Medical Emergency	25%
Emergency Room Hospital Charges	20% - 35%
Professional Charges	25%
Urgent Care Facility Services - Hospital Based Hospital Charges	20% - 35%
Professional Charges	25%
Urgent Care Facility Services - Free Standing Facility Services	25%
Professional Charges	25%
Maternity Services	
Hospital Charges	20% - 35%
Physician Charges	25%
Prenatal Office Visits	25%
Routine Newborn Care Inpatient Hospital Charges	20% - 35% (no deductible)
Physician and Lab Charges	0% (no coinsurance, no deductible)
Preventive Services	
Adult Exams and Tests Mammogram, gyno exam and pap, proctoscopic and colonoscopic exams, PSA tests, bone density tests	25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $130 for colonoscopy & sigmoidoscopy
Adult Immunizations for Pneumonia and Flu	Not covered
Well-Child Checkups and Immunizations	25% (no deductible) 0% (no deductible for County Health Department) *(through age 5)*
Mental Health Services	
Mental Health Care Inpatient Services *(Inpatient services must be certified. Pre-certification is strongly recommended.)* **Max**: One inpatient day may be exchanged for two partial hospital days.	20% - 35% 21 days *(No max for severe conditions)*
Outpatient Services With required referral or EAP counselor referral	25% **Max**: 40 visits *(No max for severe conditions)*
With NO required referral or EAP counselor referral	50% **Max**: 20 visits *(No max for severe conditions)*

BENEFIT YEAR 2003

BASIC	IN-NETWORK MANAGED CARE	OUT-OF-NETWORK MANAGED CARE
$15/visit (no deductible)	$15/visit (some lab & diagnostic included)	35%
25%	25%	35%
25%	25%	35%
25%	$100 copay	Covered under In-Network Benefit
20% - 35%	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	Covered under In-Network Benefit
25%	25%	25%
20% - 35%	$25/visit	$25/visit
25%	25%	35%
25%	$25/visit	$25/visit
25%	25%	35%
20% - 35%	25%	35%
25%	25%	35%
25%	$50 global copay for all prenatal care	35%
20% - 35% (no deductible)	25%	35%
0% (no coinsurance, no deductible)	25%	35%
25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $130 for colonoscopy & sigmoidoscopy	$15/visit (periodic physicals covered, including PSA, PAP, basic blood panel, and limited lab work) $0 co-pay for mammogram 25% for bone density scan, sigmoidoscopy, colonoscopy, proctoscopy	35%
Not covered	$15 with office visit (Allergy shots 25%, with no deductible in-network)	35%
25% (no deductible) 0% (no deductible for County Health Department) *(through age 5)*	$15/visit **Max**: Academy of Pediatrics Definitions *(through age 18)*	35%
20% - 35% 21 days *(No max for severe conditions)*	25% 21 days *(No max for severe conditions)*	35%
25% **Max**: 40 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35%
50% **Max**: 20 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS	TRADITIONAL
Chemical Dependency	
Inpatient Services* *(Inpatient services must be certified. Pre-certification is strongly recommended.)*	20% - 35%
Outpatient Services* With required referral or EAP counselor referral	25% **Max**: 40 visits and Dollar Limit*
With NO required referral or EAP counselor referral	50% **Max**: 20 visits and Dollar Limit*
*Dollar Limit Max for all Chemical Dependency Services: Combined inpatient/outpatient max of $6,000/year; $12,000/lifetime; $2,000/year thereafter.	
Rehabilitative Services	
Physical, Occupational, and Speech Therapy Inpatient Services *(Inpatient services must be certified. Pre-certification is strongly recommended.)*	20% - 35% **Max**: 60 days
Outpatient Services – Hospital	20% - 35% **Max**: $2,000/year for all outpatient ($10,000/year for prior auth. conditions)
Outpatient Services – Non-Hospital	25% **Max**: $2,000/year for all outpatient ($10,000/year for prior auth. conditions)
Alternative Health Care Services	
Acupuncture	25% (plus charges over $30/visit)
Naturopathic	25% (plus charges over $30/visit)
Chiropractic	25% (plus charges over $30/visit) **Max**: 25 visits in any combination for alternative health care
Extended Care Services	
Home Health Care *(Physician ordered/prior authorization recommended)*	25% **Max**: 70 days
Hospice	25% (20% - 35% if hospital-based) **Max**: 6 months
Skilled Nursing	25% (20% - 35% if hospital-based) **Max**: 70 days
Miscellaneous Services	
Dietary/Nutritional Counseling *(When medically necessary and physician ordered)*	20% - 35% **Max**: $250
Durable Medical Equipment, Appliances, and Orthotics *(Prior authorization required for amounts >$500)*	25% **Max**: $100 for foot orthotics (per foot)
PKU Supplies	25%
Transportation *(Limited to reasonable one-way expenses for services not available in MT)*	25%
Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)* Transplant Services **Lifetime Maximums:**	25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum

BENEFIT YEAR 2003

	BASIC	IN-NETWORK MANAGED CARE	OUT-OF-NETWORK MANAGED CARE
	20% - 35%	25%	35%
	25% **Max**: 40 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35%
	50% **Max**: 20 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35%
	20% - 35% **Max**: 60 days	25% **Max**: 60 days	35% **Max**: 60 days
	20% - 35% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
	25% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits	35%
	25% (plus charges over $30/visit)	Not covered	Not covered
	25% (plus charges over $30/visit)	Not covered	Not covered
	25% (plus charges over $30/visit) **Max**: 25 visits in any combination for alternative health care	$15/visit **Max**: 20 visits for chiropractic subject to required referral	Not covered
	25% **Max**: 70 days	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
	25% (20% - 35% if hospital-based) **Max**: 6 months	25% **Max**: 6 months	35% **Max**: 6 months
	25% (20% - 35% if hospital-based) **Max**: 70 days	25% **Max**: 30 days instead of hospitalization	35% **Max**: 30 days instead of hospitalization
	20% - 35% **Max**: $250	$15/visit **Max**: no limit	35%
	25% **Max**: $100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)	35%
	25%	0% (Plan pays for 100% for services required under State mandate.)	35%
	25%	Ambulance service & organ transplant only	Not covered
	25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum	25% $500,000 lifetime maximum with $5,000 of the maximum available for travel to and from the facility.	Not covered

MEDICAL INSURANCE PLANS - 2003

Administered by:
Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315 • www.bluecrossmontana.com
New West Health Plan • 1-800-290-3657 or 457-2202 • www.newwesthealth.com
Peak Health • 1-866-368-7325 • www.healthinfonetmt.com

WHO IS ELIGIBLE?

Employees, Legislators, retirees, and COBRA members of the State Benefit Plan are eligible for the Medical Insurance Plan. Enrollment is only allowed during these circumstances:

- within a new employee's initial 31-day enrollment period;
- within 63 days of becoming a dependent (through marriage, birth, adoption, pre-adoption, or court-ordered custody/legal guardianship);
- within 63 days of losing eligibility (not cancellation) for other group coverage;
- within 63 days of losing an employer's contribution toward other group coverage, sustaining a major increase in out-of-pocket costs, or losing benefits.

Notify your Agency Insurance Personnel when one of the above circumstances occurs (within the specified time-frames) to enroll dependents.

CLICK ON IT!

Learn more about your insurance administrator's customer service by visiting their web site at:

www.bluecrossmontana.com

www.newwesthealth.com

www.healthinfonetmt.com

GENERAL INFORMATION

The State of Montana offers two indemnity insurance plans and three managed care plans to choose from:

- **Traditional Plan**
- **Basic Plan**
- **Blue Choice**
- **New West Health Plan**
- **Peak Health Plan**

INDEMNITY PLANS

The Traditional and Basic indemnity plans are administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service, and provides notice to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network – providers who have agreed to accept certain plan allowances.

How They Work

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, he or she will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. **Please verify a provider is currently participating by calling BCBS.**

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay, referred to as balance billing.

Preferred Hospital Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals offer services for members on the Traditional or Basic plans that are subject to lower coinsurance rates. Please contact BCBS web site (listed above) for a list of Parrticipating Hospitals. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling your plan's customer service phone number, listed at the top of this page.

Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

MANAGED CARE PLANS

Blue Choice, New West, and Peak Health are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in costs and requirements for receiving services.

How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required referral is obtained).

In-Network Benefits

When joining a managed care plan, members choose a Primary Care Physician (PCP) who is a member of the plan's network providers. The PCP oversees the member's care and generally gives referrals for any specialty care that is needed. While a PCP referral is not required for the plan member to see an in-network specialist, referrals are required from a plan physician to see an out-of-network specialist and still receive the plans' in-network benefits.

Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, with no required referral, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

Out-of-State Services

Plan members may receive standard benefits for medical services in other states for a medical emergency if they obtain a required referral, or if their plan accesses an out-of-state network. Please contact your plan administrator for specific provider network information.

SERVICE AREAS

The Traditional Plan and Basic Plan are both available to members living anywhere in Montana or throughout the world. These plans include services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

IMPORTANT!
BCBS providers for the Traditional and Basic plans are different than the BCBS providers for the Blue Choice plan. A provider may be a member provider on one or both plans.

The Standard Managed Care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana.

Blue Choice

This plan is available in most of Western Montana (except Bozeman) and many other towns including Billings, Great Falls, Havre, and Miles City.

New West Health Plan

This plan is available in most of Western Montana (except Bozeman) and many other towns including Billings, Great Falls, Havre, and Miles City.

Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, Miles City, and the surrounding communities.

MEDICAL INSURANCE COST COMPARISONS

The following medical insurance cost comparisons show how each plan would process the same service, and what costs the plan member would be responsible for paying. The example is **cumulative** with respect to deductibles and coinsurance. The first line of each example shows the total costs to the member. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on page 6. These examples assume the services were for one member. This is simply an example for ease of plan comparison and is not a guarantee that similar services will process identically.

EMPLOYEES, LEGISLATORS, & COBRA			TRADITIONAL	BASIC	MANAGED CARE PLANS	
Sample Services	**Allowable Charge**				**In-Network**	**Out-of-Network**
Office visits 1, 2, & 3 ($50 each)	**$150**	**You pay ➡**	**$76**	**$45**	**$45**	**$150**
Copay costs				$45 ($15/each)	$45 ($15/each)	
Costs applied to deductible			$50*			$150
Coinsurance costs			$26			
Lab charges with office visit 1	**$75**	**You pay ➡**	**$75**	**$75**	**$75**	**$75**
Copay costs						
Costs applied to deductible			$75	$75	$75	$75
Coinsurance costs						
Specialist visit (i.e. dermatologist)	**$200**	**You pay ➡**	**$200**	**$200**	**$15**	**$200**
Copay costs					$15	
Costs applied to deductible			$200	$200		$200
Coinsurance costs						
Preferred hospital inpatient	**$8,500**	**You pay ➡**	**$1,290**	**$2,524**	**$2,225**	**$2,075**
Copay costs						
Costs applied to deductible			$110	$1,030	$225	$75
Coinsurance costs			$1,180	$1,494	$2,000	$2,000
Nonpreferred hospital inpatient	**$8,500**	**You pay ➡**	**$2,175**	**$3,645**	**$2,225**	**$2,075**
Copay costs						
Costs applied to deductible			$110	$1,030	$225	$75
Coinsurance costs			$2,065	$2,615	$2,000	$2,000

*First two office visits are exempt from the deductible.